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HISTORICALLY an individual who desired to hold a hospital liable for an injury to him had two obstacles to overcome. In the first place, he had to be able to bring suit against the hospital; second, he had to prove that his injury was caused by a negligent act for which the hospital was legally responsible. As this article will attempt to point out, these obstacles are being steadily broken down, and the chances of an injured patient maintaining a successful action against a hospital are steadily improving. An examination will also be made of some of the far-reaching implications of this process, with particular attention to the question whether, given this trend, negligence is still a viable doctrine for allocating the burden of legal liability.

Hospital Immunity

Charitable Immunity

The first problem an injured individual faces is whether he can bring suit against the hospital in which the injury occurred. This problem is posed by the doctrines of charitable and governmental immunity from tort liability.

Although a majority of states at one time recognized the doctrine of immunity from tort liability of charitable (or nonprofit) institutions,[1] and hospitals in particular, presently most states have wholly rejected the doctrine.[2]

At least four theories have been developed by courts to justify the doctrine of charitable immunity. The theory most relied upon has been the trust fund theory, which holds generally that the funds of a charity constitute a trust and that payment of tort claims would act as a diversion to specific individuals of such funds from the charitable purposes

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1. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 127, at 1020 (3d ed. 1964) [hereinafter cited as PROSSER].

2. The status of the law is set forth in PROSSER § 127 at 1021-24.

for which they were intended.[3] Several states using this theory have made recovery against the charity depend on the presence of nontrust assets—that is, property not directly and exclusively utilized in the charity's work, including proceeds from liability insurance or sometimes income-producing commercial property.[4] As one writer has pointed out, this determination has no more than a conceptual consistency with the trust fund theory of immunity, which rests on preserving the charity by safeguarding its trust assets.[5] The funds used by the charity to purchase liability insurance are, in essence, a diversion of trust assets from charitable uses to pay personal injury claims; and the use of nontrust assets, such as commercial rental property, to satisfy a tort judgment leads to a loss of revenue to the institution. The loss adversely affects its ability to perform its charitable functions and causes an indirect depletion of its trust funds.

Under another theory, the implied waiver theory, it is argued that a beneficiary of a charity, such as a hospital patient, assumes the risk of negligence by the charity and impliedly waives his right to recover for harm incurred when he accepts the charity's benefits.[6] Recovery in some states using this theory depends on the relationship of the injured person to the charitable institution. In these states immunity is denied the hospital only where the injury is incurred by a "beneficiary," that is, a hospital patient, and granted where the injury is incurred by an employee or a stranger. The last category includes visitors, private nurses, and private patients of physicians renting office space in the hospital.[7]

Most states recognizing charitable immunity, however, do not distinguish between paying and nonpaying patients, since all patients are recipients of the charity; payments made by patients for treatment are devoted to the overall charitable work of the hospital, and not to profit.[8]

A third theory advanced to support charitable immunity is that

3. *Id.* at 1020.

4. Horty, *The Status of the Doctrine of Charitable Immunity in Hospital Cases*, 25 OHIO ST. L.J. 343, 345 (1964).

5. *Id.*

6. *See* Powers v. Massachusetts Homeopathic Hosp., 109 F. 294, 303-04 (1st Cir. 1901); Wilcox v. Idaho Falls Latter Day Saints Hosp., 59 Idaho 350, 361, 82 P.2d 849, 853-54 (1938); St. Vincent's Hosp. v. Stine, 195 Ind. 350, 354-55, 144 N.E. 537, 541-42 (1924); Forrest v. Red Cross Hosp., 265 S.W.2d 80, 81 (Ky. App. 1954); Duncan v. Nebraska Sanitarium Benev. Ass'n, 92 Neb. 162, 163-64, 137 N.W. 1120 (1912).

7. See cases cited in PROSSER § 127, at 1022 n.59. *See also* Horty, *supra* note 4, at 346.

8. Horty, *supra* note 4, at 347.

the doctrine of respondeat superior applies only when the negligent act is done to aid the master (here, the hospital) in making a profit;[9] and, of course, charitable institutions are, by definition, not-for-profit institutions. The states adopting this theory impose liability on the hospital only when the hospital is itself negligent, and recognize immunity when the hospital's employees are negligent;[10] the nature of the negligent act, therefore, determines the extent of charitable immunity.

A fourth, general public policy theory has been advanced to support charitable immunity. Now an anachronism, this theory was based on the argument that the beneficiary, the patient, must suffer his injuries without compensation so that the hospital might not be damaged.[11]

Regardless of the theory used, however, the charitable institution is not immune when the particular activity resulting in the injury is of a commercial nature, even though the revenues from such activity were or would be devoted entirely to charitable purposes.[12]

The doctrine of charitable immunity, when it first appeared in the United States in 1876,[13] developed primarily because charitable institutions could not financially withstand the cost of litigation and tort liability.[14] Such a doctrine has little application to the modern hospital, however;[15] and there is no evidence of a greater crippling of charities or an increased deterrence to donations in non-immunity states than in immunity states.[16] In essence, the significant financial consideration to the hospital is the cost of the liability insurance premium and not the potential full award of damages. This added cost of insurance, while an increasing burden as described below,[17] is hardly a sufficient reason to justify imposing on innocent victims the burdens of their plight. Therefore, whatever need charitable immunity formerly met, it has had its day, as many states have recognized.

9. *E.g.*, Hearns v. Waterbury Hosp., 66 Conn. 98, 33 A. 595 (1895).

10. *E.g.*, Bader v. United Orthodox Synagogue, 148 Conn. 449, 172 A.2d 192 (1961); Peden v. Furman Univ., 155 S.C. 1, 151 S.E. 907 (1930); Roberts v. Ohio Valley Gen. Hosp., 98 W.Va. 476, 127 S.E. 318 (1925); Smith v. Congregation of St. Rose, 265 Wis. 393, 61 N.W.2d 896 (1953).

11. See cased cited in PROSSER § 127, at 1021 n.43.

12. See cases cited *id.* at 1022 nn.52-55.

13. McDonald v. Massachusetts Gen. Hosp., 120 Mass. 432 (1876).

14. *See id.*

15. In 1968, for example, total hospital assets in the United States exceeded 31 billion dollars. 43 HOSPITALS 474, Table 1 (Aug. 1969) (Journal of the American Hospital Asociation).

16. President & Directors of Georgetown College v. Hughes, 130 F.2d 810, 823 (D.C. Cir. 1942); Cohen v. General Hosp. Soc'y, 113 Conn. 188, 192-93, 154 A. 435, 436-37 (1931).

17. See text accompanying notes 130-132 *infra.*

Governmental Immunity

The immunity of governmental hospitals from tort liability is based on the general proposition that the government cannot be sued for the negligent acts of its agents or employees unless it consents to such suit.[18] Although this doctrine, like the doctrine of charitable immunity, is being increasingly abandoned by state courts,[19] it has proved more resilient than charitable immunity and is still the rule in the majority of states.[20] Thus state hospitals are generally immune from tort liability unless such immunity is waived by statute, as it is in several states.[21] The immunity of hospitals of political subdivisions of the state—counties, districts, and municipal corporations—is far more restricted than the immunity of state hospitals. The hospitals of political subdivisions of the state are held in a number of states to be immune from tort liability only when the subdivision, in operating the hospital, is engaged in a governmental, rather than proprietary function.[22] A hospital is said to be engaged in a governmental function when its acts are performed for the good of the public as a whole, and the benefits from these acts extend beyond the corporate limits of the subdivision.[23] On the other hand, a hospital is said to be engaged in a proprietary function when its benefits are specially limited to the corporate boundaries of the political subdivision.[24]

In making this distinction, some courts hold that where a statute imposes a mandatory duty on the political subdivision to establish a hospital, the function is a governmental one; but if the statute is merely permissive, authorizing but not requiring the establishment of a hospital, the function may be a proprietary one.[25] Other courts center

18. Faber v. State, 143 Colo. 240, 353 P.2d 609 (1960); Lewis v. State, 96 N.Y. 71 (1884).

"[T]he origin of the idea . . . in the common law seems to have been the theory, allied with the divine right of kings, that 'the King can do no wrong,' together with the feeling that it was necessarily a contradiction of his sovereignty to allow him to be sued as of right in his own courts." PROSSER § 125, at 996.

19. A good discussion of this trend may be found in Muskopf v. Corning Hosp. Dist., 55 Cal. 2d 211, 213-17, 359 P.2d 457, 458-60, 11 Cal. Rptr. 89, 90-92 (1961).

20. For a state-by-state analysis, see IIA HOSPITAL LAW MANUAL, *Negligence* ch. III, at 20-29 (1968).

21. *Id.* The immunity of federal hospitals has been waived to a large degree by the Federal Tort Claims Act, enacted in 1945. 28 U.S.C. §§ 1346(b), 2671-2680 (1958).

22. IIA HOSPITAL LAW MANUAL, *Negligence* ch. III, at 14-15 (1959).

23. *See id.*

24. *See id.*

25. *E.g.*, Wittmer v. Litts, 248 Iowa 648, 80 N.W.2d 561 (1957). *See also* IIA HOSPITAL LAW MANUAL, *Negligence* ch. III, at 14-15 (1959).

the discussion of whether the operation of a hospital is a governmental or proprietary function upon whether the hospital admits paying patients. These courts hold either that those particular patients who pay may sue the hospital for negligence,[26] or that the mere admission of some paying patients renders the entire operation of the hospital a proprietary function regardless of the status of the particular patient injured.[27]

The doctrine of governmental immunity, especially when applied to the hospital, is as unsatisfactory and anachronistic as the doctrine of charitable immunity. However practical the doctrine may have been when government was limited in its activities and revenues, it is no longer so under the modern conditions of enormous government revenues and the greatly expanded role of the government in the hospital field. In addition, the distinction between governmental and proprietary functions (which, for example, generally deems the operation of a hospital to be a governmental function,[28] but the paving and cleaning of streets to be a proprietary one)[29] is technical, unrealistic, and unjustified. The primary reason for the slower demise of this doctrine than the doctrine of charitable immunity is that even courts expressing dissatisfaction with the doctrine hold the view that the abrogation of such a long-held precedent should be by legislative rather than judicial action.[30] This view is perhaps justified. In California, after the California Supreme Court abolished the doctrine of governmental immunity in the 1961 case of *Muskopf v. Corning Hospital District*,[31] the state legislature passed a two year moratorium to enable itself to examine the entire immunity question.[32] Following the moratorium the legislature enacted comprehensive legislation that restored, with some significant exceptions, the general rule of governmental immunity.[33]

Respondeat Superior and Corporate Negligence

Once the injured individual is able to bring suit against the hos-

26. Suwanee County Hosp. Corp. v. Golden, 56 So. 2d 911 (Fla. 1952).

27. Stolp v. Arkansas City, 180 Kan. 197, 303 P.2d 123 (1956); Anderson v. Portland, 130 Me. 214, 154 A. 572 (1931).

28. IIA HOSPITAL LAW MANUAL, *Negligence* ch. III, at 16 (1959).

29. See cases cited in PROSSER § 125, at 1008 n.20.

30. Faber v. State, 143 Colo. 240, 242, 353 P.2d 609, 610 (1960).

31. 55 Cal. 2d 211, 359 P.2d 457, 11 Cal. Rptr. 89 (1961).

32. Cal. Stats. 1961, ch. 1404, at 3209; *see* Corning Hosp. Dist. v. Superior Court, 57 Cal. 2d 488, 370 P.2d 325, 20 Cal. Rptr. 621 (1962); Thelander v. Superior Court, 58 Cal. 2d 828, 376 P.2d 571, 26 Cal. Rptr. 643 (1962).

33. CAL. GOV'T CODE §§ 815, 815.2. For a discussion and analysis of this legislation, see Note, *Notes on the California Tort Claims Act*, 19 HAST. L.J. 561 (1968).

pital, and as we have seen, he is able to do so in an increasing number of cases, he must then prove that his injury was caused by a negligent act for which the hospital is legally liable. Hospital liability for negligence is based on either of two theories: corporate negligence or vicarious liability under the doctrine of respondeat superior.[34]

Respondeat Superior

Under the doctrine of respondeat superior an employer is liable for the tort of an employee committed within the scope of his employment.[35] For the purposes of hospital liability the central question under this doctrine is: Who is a hospital "employee"? Because the employer is not vicariously liable for the negligence of a person over whom it has no right of control, *i.e.*, an independent contractor,[36] the traditional test has been the employer's right to control the employee's conduct in the performance of his duties.[37]

In general, because he has a direct contractual relationship with the patient and because the hospital has no right to control his conduct while he is administering the patient, the staff doctor has been considered an independent contracter.[38] Courts have found hospitals not liable for the acts of such physicians even though the physicians were shareholders or officers of the hospital.[39] In this regard, some courts have made a clear distinction between the professional and managerial duties of the physician and have refused to hold the hospital liable where the physician is acting in his professional capacity.[40] A few courts, however, have held that if the physician is paid a salary by the hospital, he is a servant of the hospital for purposes of respondeat superior, even

34. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 1 (1968).

35. P. MECHEM, OUTLINES OF THE LAW OF AGENCY § 349, at 237 (4th ed. 1952).

36. RESTATEMENT (SECOND) OF AGENCY § 2(3) (1957). *See also* P. MECHEM, *supra* note 35, § 427, at 288.

37. *See id.* § 371; IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 2-3 (1968).

38. *See* Barfield v. South Highland Infirmary, 191 Ala. 553, 559, 68 So. 30, 33 (1915); Mayers v. Litow & Midway Hosp., 154 Cal. App. 2d 413, 417-18, 316 P.2d 351, 354 (1957); Rosane v. Senger, 112 Colo. 363, 366, 149 P.2d 372, 374 (1944); Black v. Fischer, 30 Ga. App. 109, 111-12, 117 S.E. 103, 103-04 (1923); Jeter v. Davis-Fischer Sanitarium Co., 28 Ga. App. 708, 711, 113 S.E. 29, 30 (1922); Holland v. Eugene Hosp., 127 Ore. 256, 261-62, 270 P. 784, 786 (1928); Kuglich v. Fowle, 185 Wis. 124, 126-27, 200 N.W. 648, 649 (1924).

39. Barfield v. South Highland Infirmary, 191 Ala. 553, 68 So. 30 (1915); Jeter v. Davis-Fischer Sanitarium Co., 28 Ga. App. 708, 113 S.E. 29 (1922); Kuglich v. Fowle, 185 Wis. 124, 200 N.W. 648 (1924).

40. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 3 (1957); *see* Barfield v. South Highland Infirmary, 191 Ala. 553, 559, 68 So. 30, 33 (1915); Kuglich v. Fowle, 185 Wis. 124, 126-27, 200 N.W. 648, 649 (1924).

though such employment may not give the hospital any right to control the physician's professional acts.[41]

In 1955, the California Supreme Court, in the leading case of *Seneris v. Haas*,[42] made yet another inroad into the independent contractor doctrine by announcing the doctrine of apparent or ostensible agency. The court held that if the hospital leads the patient to believe that a professional person is its employee, then it may be held liable for his negligence.[43] The case concerned an anesthesiologist who worked at no other hospital and who was one of six anesthesiologists on the staff of the defendant hospital. The hospital had procured the services of the physician for the patient, although the doctor himself billed the patient. The court held that it was a jury question whether or not the patient was led to believe that the professional individual was an employee of the institution.[44] This doctrine of apparent or ostensible agency has been applied by several other courts,[45] including the Montana Supreme Court in the 1966 case of *Kober v. Stewart*.[46] In that case, the hospital's X-ray department was operated under contract with a private clinic. The clinic supplied a qualified radiologist as the department's director and was paid 35 percent of the gross receipts. The hospital hired all X-ray technicians, owned the equipment, and made the charge to the patient. The patient had no contract with the radiologist; the hospital called the doctor to read the patient's films. The court held that it was error for the trial court to give a summary judgment for the hospital on the ground that the radiologist was an independent contractor,[47] and that it was an issue of fact for the jury to determine whether or not the doctor was an agent of the hospital.[48]

The doctrine of apparent agency reflects the judicial antipathy toward, and illustrates the judicial circumvention of the independent contractor doctrine. There is no apparent significance in whether or not the relationship between the physician and the hospital is such that the public believes that the physician is acting as the hospital's agent; nevertheless, the doctrine of apparent agency has hastened the de-

41. Gilstrap v. Osteopathic Sanitorium Co., 224 Mo. App. 798, 24 S.W.2d 249 (1929); Vaughn v. Memorial Hosp., 100 W.Va. 290, 130 S.E. 481 (1925).

42. 45 Cal. 2d 811, 291 P.2d 915 (1955).

43. *Id.* at 831-32, 291 P.2d at 927.

44. *Id.*

45. *See* Stanhope v. Los Angeles College of Chiropractic, 54 Cal. App. 2d 141, 146, 128 P.2d 705, 708 (1942); Middleton v. Frances, 257 Ky. 42, 44, 77 S.W.2d 425, 426 (1934); Agnew v. Mullenix, 11 So. 2d 106, 107 (La. App. 1942).

46. 417 P.2d 476 (Mont. 1966).

47. *Id.* at 478-79.

48. *Id.* at 479-80.

mise of the independent contractor doctrine.

Resident and intern physicians (as opposed to staff doctors) are generally considered to be employees[49] for whose negligence the hospital is liable.[50] Because the resident or intern is not employed by the patient and is usually on salary, courts generally apply respondeat superior without discussing the element of control.[51]

Nurses are clearly employees of the hospital when performing their routine nursing functions, and even when performing professional acts.[52] The nurse's duties to the patient as an employee of the hospital include the duty to challenge and inquire into a physician's judgment if she, as a professional, knows or should know that the physician's orders are wrong or unclear. In a recent (1967) Kentucky case, *Arnold v. Haggin Memorial Hospital*,[53] two nurses, in accordance with the orders of the patient's doctor, forced the protesting patient to get out of bed following a hysterectomy and walk in the corridor for exercise. While being walked, she fell and allegedly sustained a ruptured disk. The Kentucky Supreme Court held that although the nurses were acting in accordance with the orders of the patient's physician, this did not excuse them from using their independent judgment for the patient's protection.[54] The court ruled that the question of whether or not the nurses should have followed the physician's orders in view of plaintiff's protestations and condition should have been submitted to the jury.[55] The 1962 Louisiana case of *Norton v. Argonaut Insurance Co.*[56] focused on the additional responsibility of a nurse to obtain clarification of an ambiguous order from the patient's physician. The infant patient had been receiving the drug digitalis orally. On one particular occasion, the doctor (who, incidentally, was also found to be negligent) wrote a prescription as follows: "Give 3 cc. lanoxin today for one dose only."[57] Apparently he intended the medication to be administered in oral form; but the nurse gave it by injection and it proved to be a fatal overdose. The nurse had not called the attending doctor for clarification; she was not even aware that the drug came in the oral form. She was, however, aware that the prescription was a large dose;

49. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 8-11 (1962).
50. *Id.*
51. *Id.* at 8.
52. *Id.* at 11-14b.
53. 415 S.W.2d 844 (Ky. 1967).
54. *Id.* at 466.
55. *See id.*
56. 144 So. 2d 249 (La. Ct. App. 1962).
57. *Id.* at 259-60.

indeed, she had asked two other doctors for clarification and they told her, in effect, that if the prescribing physician ordered the medication then she should administer the prescription. The nurse (and thus the hospital) was held liable for failing to obtain a clarification of the prescription from the patient's physician.[58]

There is one important caveat to the general rule of the liability of a hospital for the negligence of residents, interns, nurses, and other hospital employees. Under the borrowed servant doctrine, some courts have held that such a hospital employee may temporarily become an employee under the control and supervision of the attending physician who himself is an independent contractor. This new employer becomes liable for the negligence of the employee under respondeat superior and the hospital is insulated from liability.[59]

That the doctor orders treatment clearly does not make a person carrying out the order the borrowed servant of the physician; as stated previously,[60] such an employee must use his independent judgment in protecting the patient, or else the hospital will be vicariously liable. In the operating room, however, when the surgeon by necessity must be in exclusive and complete control of all surgical personnel in the room, the borrowed servant doctrine may apply.[61] Under the older, more extreme form of this doctrine, the surgeon is "Captain of the Ship" and hence responsible for all that goes on within the operating room. Thus in a 1949 Pennsylvania case, *McConnell v. Williams*,[62] a surgeon completing a caesarian section was held liable for the negligent act of an intern who had been assigned the task of putting silver nitrate in the eyes of the newborn infant. In actuality, the surgeon had no physical control over the intern's act;[63] but the court said that he had ultimate supervisory control and the right and responsibility to give orders to the intern.[64]

Courts, however, are abandoning the "Captain of the Ship" doctrine and are increasingly holding the hospital liable in these situations. For example, several courts have held the hospital, and not the surgeon, liable under respondeat superior for the negligence of an operating

58. *Id.* at 260-61. A hospital is also liable for the negligence of its other employees (including hospital pharmacists and non-professional employees, such as orderlies). IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 18-19 (1967).

59. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 14b-16 (1967).

60. See text accompanying notes 53-58 *supra.*

61. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 14b (1967).

62. 361 Pa. 355, 65 A.2d 243 (1949).

63. *See id.* at 358-59, 65 A.2d at 244-45.

64. *Id.* at 362-63, 65 A.2d at 246-47.

room nurse in making an improper sponge count.[65] The theory underlying these holdings has been that just because the surgeon is in complete charge of the operating room and the personnel within and has ordered some act to be performed for his patient by a hospital nurse, the nurse does not necessarily become the physician's temporary servant, thereby relieving the hospital of all responsibility for the nurse's act.[66] Instead, the character of the act performed by the nurse is important in determining liability. The physician should be able to rely upon the nurse to perform routine operating room acts, such as making the sponge count, that are a part of her usual and customary duties as an employee of the hospital. Only where the hospital truly surrenders direction and control over the nurse to the physician and where her acts involve professional decisions on the part of the surgeon, is it no longer liable as the employer for the nurse's negligence.[67]

A 1966 New York case, *Matlick v. Long Island Jewish Hospital*,[68] completely abandoned the concept of the borrowed servant doctrine. In that case, a hospital employee participating in a surgical operation was held to be under the concurrent control of the hospital and an independent anesthesiologist, on the ground that a given employee can serve the mutual interests of two employers at the same time, and that both employers can be liable for the employee's negligence. Thus, the borrowed servant exception to the doctrine of respondeat superior also seems to be a dying defense for the hospital.[69] This, coupled with the increasing restrictions on the independent contractor defense, reflects the growing number of situations in which the hospital is being held liable under respondeat superior for the torts of its employees or apparent employees.

65. *E.g.*, Rice v. California Lutheran Hosp., 27 Cal. 2d 296, 163 P.2d 860 (1945); Rural Educational Ass'n v. Bush, 42 Tenn. App. 34, 298 S.W.2d 761 (1956).

66. *See* Rice v. California Lutheran Hosp., 27 Cal. 2d 296, 303-04, 163 P.2d 860, 865 (1945).

67. Swigard v. Ortonville, 246 Minn. 339, 75 N.W.2d 217 (1956). In the course of its opinion the Minnesota court explained its rule in the following manner: "[A] hospital is liable for the negligence of its nurses in performing mere administrative or clerical acts, which acts, *though constituting a part of patient's prescribed medical treatment*, do not require the application of the specialized technique or the understanding of a skilled physician or surgeon. This rule, in recognizing that the right of control remains with the hospital as the general employer, is consistent with the nature of such acts and is in accord with the custom which in everyday practice governs the relationship between the hospital staff and the attending physicians. It is generally recognized that the nature of the acts performed, and the custom as to the control ordinarily exercised in the performance of similar acts, are factors indicative of where the right of control exists." *Id.* at 345, 75 N.W.2d at 222.

68. 25 App. Div. 2d 538, 267 N.Y.S.2d 631 (1966).

69. See text accompanying notes 60-68 *supra*.

Corporate Negligence

The other theory on which hospital liability for negligence is based, corporate negligence, is undergoing an even more significant expansion. Under the theory of corporate negligence, liability is imposed on the hospital if the hospital fails to fulfill a duty it owes directly to the patient.[70] It will be seen that the duties owed by a hospital directly to the patient have expanded in recent years, just as has the concept of who is a hospital employee for respondeat superior purposes.[71]

Traditionally, the hospital has owed a direct duty to the patient to furnish equipment that is not defective, improper, or inadequate.[72] Thus, if the harm is caused by a defect in the hospital's apparatus, as opposed to the negligent use of the apparatus by an employee, the hospital can be held directly liable under the theory of corporate negligence. There is no duty, however, to furnish the newest, most modern equipment on the market; it is enough if the hospital furnishes equipment reasonably suited to assure proper operation and customarily used in similar circumstances in other hospitals in the area.[73] However, if it does not have the proper equipment and facilities to treat adequately a patient's condition, a hospital might have a duty to transfer the patient to another hospital that does have such facilities. For example, in the 1963 California case of *Carrasco v. Bankoff*,[74] the court held the hospital liable when a patient with third-degree burns was retained in the hospital for 53 days and the institution did not have facilities for skin grafting or for the "open" method treatment of burns. Because it was established that these facilities were required for proper treatment of third-degree burns, the hospital was under a duty to transfer the patient to another hospital.

The hospital has also traditionally had the duty, as an owner of land and buildings, to exercise reasonable care with respect to the maintenance of buildings and grounds.[75] In this regard, the law of most jurisdictions makes distinctions based on the relationship between the injured person and the property owner. If the person is merely a "trespasser" or a "licensee" (one who, unlike a trespasser, has the owner's consent to enter upon the property),[76] the property owner merely has a

70. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 3 (1968).
71. See text accompanying notes 34-71 *supra*.
72. *See* IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 18a (1964).
73. Emory Univ. v. Porter, 103 Ga. App. 752, 755, 120 S.E.2d 668, 670 (1961).
74. 220 Cal. App. 2d 230, 33 Cal. Rptr. 673.
75. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 22-23 (1961).
76. PROSSER § 60, at 386-87. In California, however, a recent case has abrogated the distinctions based upon plaintiff's status as a trespasser, licensee or invitee. Rowland v. Christian, 69 Cal. 2d 108, 443 P.2d 561, 70 Cal. Rptr. 97 (1968).

duty to give warning of highly dangerous conditions of the property known to him.[77] The property owner, however, owes a higher duty to an invitee,[78] a person not merely allowed, but encouraged to enter the premises,[79] *e.g.*, hospital patients and their visitors.[80] Generally, the duty requires the exercise of reasonable care in making the premises safe for the invitee, and in warning him of dangerous conditions which are known to the property owner, or which could be discovered by him with reasonable care.[81]

The most far-reaching extension of the corporate negligence concept occurred in the celebrated 1965 Illinois case of *Darling v. Charleston Community Memorial Hospital.*[82] In this case, a cast had been applied to the patient's leg improperly and although the patient complained bitterly of pain and the nurses had noticed the toes of the patient turning blue and the odor of decayed tissue was evident, necessary competent attention was delayed to the extent that an amputation had to be performed. Among other things, the Illinois Supreme Court extended the scope of duty of the hospital by defining it in terms of the hospital's by-laws, state statutes, and accreditation rules,[83] in addition

77. PROSSER § 58, at 371-72; *id.* § 60, at 389-90.

78. IIA HOSPITAL LAW MANUAL, *Negligence* ch. I, at 23 (1961).

79. *Id.*

80. Starr v. Emory Univ., 93 Ga. App. 864, 93 S.E.2d 399 (1956) (patient); Greenfield v. Hosp. Ass'n, 258 App. Div. 352, 16 N.Y.S.2d 729 (1940) (visitor). *But see* Sandwell v. Elliott Hosp., 92 N.H. 41, 24 A.2d 273 (1942), where the court treated a visitor as a licensee. Although the charitable immunity doctrine is not recognized in New Hampshire, the fact that the hospital was of charitable nature was taken into consideration to lessen its liability. *Accord*, Nickerson v. Laconia Hosp. Ass'n, 96 N.H. 482, 79 A.2d 5 (1951).

81. In the few states that base charitable immunity on the implied waiver theory, the patient, although he may be owed a high duty of care by the hospital because he is an "invitee," will be prevented from suing the hospital for breach of that duty, since he is a "beneficiary" of the charity. See text accompanying notes 6-7 *supra.* As a practical matter, therefore, in these states the hospital really has no duty of due care whatsoever toward the patient.

82. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

83. Standards for hospital accreditation are promulgated by the Joint Commission on Accreditation of Hospitals. The Joint Commission is sponsored by the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association. Its purpose is, among other things, to establish standards for the operation of hospitals and other health care facilities, and to conduct surveys of health care institutions and accredit such institutions to assure compliance with the standards. The enactment in 1965 of Health Insurance for the Aged Act (Medicare), Pub. L. No. 89-97, 79 Stat. 290 (codified in scattered sections of 26, 42, 45 U.S.C.) heightened the work of the Joint Commission by stating that institutions participating in the Medicare program must meet and maintain certain minimum standards of patient care; the law cited the standards of the Joint Commission as constituting that minimum level of care. *See* U.S.C. §§ 1395x(e)-(g) (Supp. IV,

to the standards of care followed by other hospitals in the community.[84] The court held that, on the basis of these standards, the hospital could be found liable for failing to review the attending physician's work or to require consultation.[85] As a consequence, a hospital has a duty to be aware of the care being given a patient by his physician and to act when it becomes apparent that this care is below the standard warranted by the patient's condition. Such a duty focuses on a shared, joint responsibility for the standards of patient care; in order to conform to the standards of its own by-laws, state statutes, and accreditation standards, a hospital administration must stimulate its medical staff to establish procedures for consultation among physicians and for review of the work of each staff physician.

In a 1967 Illinois case, *Mauer v. Highland Park Hospital Foundation*,[86] the court construed *Darling* as laying the basis for imposing liability on a hospital for the imprudent or careless selection of its staff members.[87] The *Darling* rationale apparently was also applied in a 1967 Washington case, *Pederson v. Dumouchel*,[88] in which the Washington Supreme Court held that the hospital was negligent as a matter of law for allowing the deviation from the standard of good practice embodied in its own rules.[89] Clearly, the *Darling* case and its offspring, by establishing the direct duty of a hospital to furnish competent medical care or be held liable for failure to do so, have had a substantial impact on hospital liability.

In summary, both of the bases of hospital liability for negligence, corporate negligence and respondeat superior, are expanding, with the

1969). At that time the accredited hospitals numbered 4,606 which represented about 65 percent of the then existing hospitals and about 88 percent of all hospital beds. Joint Comm'n on Accreditation of Hospitals, *Preface* to PROVISIONAL DRAFT PROPOSED STANDARDS FOR ACCREDITATION OF HOSPITALS at iii (1969). In 1966 the Joint Commission undertook a study of the standards to obtain two objectives:

(a) To raise and strengthen the standards from the present level of minimum essential to the level of optimum achievable and to assure their suitability to the modern state of the art.

(b) To simplify and clarify the language of standards and interpretation to remove all possible ambiguities and misunderstandings. *Id.* The revised standards after a long and sometimes heated debate within the hospital field were adopted by the Joint Commission on August 9, 1969 and are scheduled to go into effect January 1, 1970. The impact of these much more comprehensive standards on hospital liability in light of the *Darling* case remains to be seen.

84. 33 Ill. 2d at 331, 211 N.E.2d at 257.
85. *Id.* at 333, 211 N.E.2d at 258.
86. 90 Ill. App. 2d 409, 232 N.E.2d 776 (1967).
87. *Id.* at 415, 232 N.E.2d at 779.
88. 72 Wash. 2d 73, 431 P.2d 973 (1967).
89. *Id.* at 80, 431 P.2d at 978.

result that the hospital is held legally responsible in a growing number of situations.

Res Ipsa Loquitur

As we have seen, along with the expanding opportunities for an injured individual to bring suit against a hospital has come a corresponding increase in the number of negligent acts for which a hospital is legally responsible. Even so, the individual still cannot hold the hospital liable for the injury unless he can produce persuasive evidence of the hospital's negligence.

The courts originally applied the old English doctrine of res ipsa loquitur to the many hospital cases in which the patient had been negligently injured while unconscious, under the influence of anesthesia, or otherwise incapacitated, in order to partially compensate for the almost insurmountable burden of proof facing the plaintiff in such a case.[90] Their purpose was clearly expressed by the California Supreme Court in the 1944 landmark case of *Ybarra v. Spangard*:[91]

> Without the aid of the doctrine a patient who [during the operation] received permanent injuries of a serious character, obviously the result of someone's negligence, would be entirely unable to recover unless the doctors and nurses in attendance voluntarily chose to disclose the identity of the negligent person and the facts establishing liability.[92]

The doctrine permits the plaintiff's case to go to the jury when the following factors are shown to exist:

> (1) [T]he event must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff.[93]

The doctrine, however, has been expanded in several significant respects, and, in reality, often serves a purpose far beyond its originally stated one. In the first place, the doctrine of res ipsa loquitur traditionally was inapplicable where the cause of the injury may be attributed to any one of several causes, some of which were not within defendant's control;[94] but this principle has been modified in recent cases. In the 1966 case of *Larrabee v. United States*,[95] a child, delivered by a military

90. See the discussion in Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944).
91. 25 Cal. 2d 486, 154 P.2d 687 (1944).
92. *Id.* at 490, 154 P.2d at 689.
93. PROSSER § 39, at 218.
94. *Id.* at 222-23.
95. 254 F. Supp. 613 (1966).

physician in an Air Force hospital in California, received birth injuries resulting in blindness in one eye; plaintiff alleged that the negligent use of forceps by the physician was the cause of the damage. Although there was also testimony indicating an intra-uterine infection as a possible causative factor, the court permitted res ipsa loquitur to be invoked.[96] The court quoted with approval the language of an earlier California case which said that the doctrine is applicable "where, in the light of past experience, (a) the accident was *probably* the result of someone's negligence and (b) the defendant is *probably* the responsible person [and that in such cases] [t]he plaintiff need not produce evidence excluding all possible causes other than defendant's negligence."[97] To the same effect is a 1966 Wisconsin Supreme Court case, *Beaudoin v. Watertown Memorial Hospital*.[98] In that case, plaintiff alleged that she received second-degree burns during surgery (for removal of a vaginal polyp). Although the defendant's evidence suggested other possible causes of the burns, the court held that res ipsa was still appropriate under the circumstances.[99]

The doctrine has been broadened in a second respect. As stated previously, one of the preconditions for the invocation of res ipsa is that the injury was caused by an instrumentality within the defendant's exclusive control. In some recent cases, however, the "instrumentality" has been extended to persons as well as objects or equipment. One example is the 1967 Montana Supreme Court case of *Gormley v. Montana Deaconess Hospital*.[100] The plaintiff had suffered a broken arm during a grand mal seizure occurring when she was either unconscious or under the influence of drugs following a surgical hysterectomy. The court held the doctrine applicable, saying that it was not necessary for the plaintiff to prove the precise "thing" causing her injury and that the hospital nurses were the "instrumentalities" whose negligence *could* have caused the injury.[101]

Res ipsa has been broadened in yet a third respect. One of the conditions usually listed as necessary for the application of the doctrine is that the injury must not have been the result of any voluntary action on the part of the injured party. In the 1967 case of *Vistica v. Presbyterian Hospital and Medical Center*,[102] the California Supreme

96. *Id.* at 616.
97. *Id., quoting* Inouye v. Black, 238 Cal. App. 2d 31, 33, 47 Cal. Rptr. 313, 315 (1965).
98. 32 Wis. 2d 132, 145 N.W.2d 166 (1966).
99. *Id.* at 138, 145 N.W.2d at 169.
100. 149 Mont. 12, 423 P.2d 301 (1967).
101. *Id.* at 20-22, 423 P.2d at 305-06.
102. 67 Cal. 2d 465, 432 P.2d 193, 62 Cal. Rptr. 577 (1967).

Court significantly modified the above condition on the applicability of res ipsa. Mrs. Vistica, who had had a long history of mental illness and previous suicide attempts, was admitted to the Presbyterian Hospital Psychiatric Unit, which operated on the "open ward" pattern. Ten days after admission to the hospital, she committed suicide. The day before her suicide, the hospital became aware that she might jump from a partially opened, transome type window located in the ward solarium; and her physician, upon being notified of this, ordered 24-hour surveillance of the patient. Although the doctor reemphasized to the nurses on the following day that the patient was not to be left alone,[103] that evening Mrs. Vistica was left unattended for about eight minutes; the only nurse on the ward was busy with other patients at the far end of the hall. Shortly thereafter, the patient's body was found lying on the ground beneath the solarium window. The solarium furniture was found arranged so that a person could climb up to the window and jump out. There was uncontested evidence that the "open ward" system, which involves unlocked doors, was sound.[104]

The California Supreme Court held, among other things, that "a plaintiff may properly rely on *res ipsa loquitur* even though he has participated in the events leading to the accident if the evidence excludes his conduct as the responsible cause."[105] The trial court failed to explain to the jury that decedent's voluntary conduct had to be "the responsible cause of her death" in order not to entitle her to the benefit of res ipsa.[106]

The 1968 case of *Meier v. Ross General Hospital*[107] makes it even clearer that res ipsa loquitur can be used to establish the negligence of a hospital that is responsible for the care of a mentally disturbed patient with known suicidal tendencies who succeeds in committing suicide while in the hospital's care. Under circumstances nearly identical to those in *Vistica*, the California Supreme Court held:

> "The plaintiff [decedent] is seldom entirely static, and it is not necessary that he be completely inactive, but merely that there

103. Because the psychiatric ward was operated on the "open ward" pattern—so that patients would not feel imprisoned—the patient was relatively free from restraint, and thus the need for suicide precautions was particularly evident to her doctor. *Id.* at 467, 432 P.2d at 195, 62 Cal. Rptr. at 579.

104. *Id.*

105. *Id.* at 470, 432 P.2d at 196, 62 Cal. Rptr. at 581, quoting with approval the language of the text from Zentz v. Coca Cola Bottling Co., 39 Cal. 2d 436, 444-45, 247 P.2d 344, 348-49 (1952).

106. Vistica v. Presbyterian Hosp., 67 Cal. 2d 465, 470-71, 432 P.2d 193, 196, 62 Cal. Rptr. 577, 580 (1967).

107. 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968).

> be evidence removing the inference of his own responsibility". . . . In the present case, decedent had attempted suicide and had been placed in the hospital because of his depressed state and physical injuries. Under such circumstances . . . those charged with the care and treatment of a patient, who know of facts from which it might reasonably be concluded that a patient would be likely to harm himself in the absence of preclusive measures, must use reasonable care to prevent such harm.[108]

It is clear in the two above cases that the court is not eliminating the concept of contributory negligence from the set of preconditions to the application of res ipsa loquitur. It is saying, rather, that for a plaintiff's own actions to constitute a defense on the grounds that they are the "responsible cause" of the injury, the plaintiff must be responsible for his actions. The court is thus holding that where the plaintiff is mentally disturbed to the point that there is a known danger of his attempting to take his own life and for those reasons he has been placed in the professional care of a hospital, it is the hospital that is responsible for the patient's acts, not the patient. The hospital therefore is the "responsible cause" of the injury, not the mentally disturbed patient. The effect of the above decisions is to enlarge the scope of hospital liability by allowing such patients to recover.

The most significant extension of the doctrine of res ipsa loquitur, however, was made by the California Supreme Court in the case of *Clark v. Gibbons*.[109] In that case, the anesthesia wore off too soon and the operation was therefore concluded prematurely. The condition of the patient prevented a second operation in time to achieve success. There was evidence, independent of the doctrine of res ipsa, sufficient to support the jury finding of negligence against the anesthesiologist and surgeon. However, the trial court also instructed the jury on res ipsa, and the supreme court upheld that instruction, stating that this was a proper case for it.[110] There was evidence that when due care is used, premature termination of anesthesia is rare; but there was absolutely no evidence indicating that in those few cases in which an anesthetic *does* terminate prematurely, it is more probably than not caused by negligence. Thus, as two justices vigorously pointed out, there was no basis whatever for inferring the most important precondition to the application of res ipsa: that the accident be of a kind that ordinarily bespeaks a negligent cause.[111] The majority did not accept rarity (of

108. *Id.* at 427, 445 P.2d at 524-25, 71 Cal. Rptr. 903 at 908-09.

109. 66 Cal. 2d 399, 426 P.2d 525, 58 Cal. Rptr. 125 (1967).

110. *Id.* at 414, 426 P.2d at 535, 58 Cal. Rptr. at 135.

111. *Id.* at 415-16, 422, 426 P.2d at 536-37, 541, 58 Cal. Rptr. at 136-37, 141 (concurring opinions of Traynor, C.J., and Tobriner, J.).

accidents when due care is used) alone as a basis for res ipsa.[112] It stated that when such rarity is combined with proof of specific acts of negligence of a type that would have caused the injury complained of, then "the likelihood of a negligent cause may be sufficiently great that the jury may properly conclude that the accident was more probably than not the result of someone's negligence."[113] Although that statement might be appropriate for counsel to make in arguing to the jury that it could infer from evidence of defendant's negligent conduct that such conduct caused injury, wholly without regard to the doctrine of res ipsa, it has no relation to res ipsa itself. Res ipsa loquitur involves the inferences of negligence that may be drawn from the mere happening of the accident; if the injury, itself, does not give rise to these inferences, then the addition of direct evidence of negligence, which rationally has nothing to do with the doctrine, should not make res ipsa applicable.

As Justice Tobriner pointed out, "in that limited number of cases in which rare and inexplicable accidents occur in the operating room," the doctrine seems to be serving a new purpose.[114] This new purpose is

112. In some cases the California Supreme Court has relied upon the rarity of the accident alone to support an inference of negligence. In most of these cases there was a calculated risk of injury to the patient inherent in the medical operation, risks which a careful physician would balance against the gains to be expected from the treatment. As one writer notes: "It is inevitable that even minor injury, injections . . . and many other medical procedures should occasionally produce serious injury or fatality which is, nevertheless, no ones fault." Rubsamen, *Res Ipsa Loquitur in California Medical Malpractice Law: Expansion of a Doctrine to the Bursting Point*, 14 STAN. L. REV. 251, 270 (1962). Furthermore, it is implicit in the phrase "calculated risk" that the possible injurious result will be unusual. California courts, says Rubsamen, seem to apply a logic to this situation which can be expressed in the following syllogistic form:

> Major premise: Certain types of treatment are very common in medicine.
> Minor Premise: It is rare that trouble develops following such treatment.
> Conclusion: If trouble does follow such treatment, an inference arises that someone has been negligent. *Id.*
> But to say that it ordinarily does not happen absent negligence is a statement that cannot be made without the support of an expert witness. If there is medical proof of an inevitable occurence of an untoward event, then there is no logical basis for the application of res ipsa loquitur. *Id.* at 271.

Wolfsmith v. Marsh, 51 Cal. 2d 832, 337 P.2d 97 (1959); Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955); Cavero v. Franklin Gen'l Benevolent Soc'y, 36 Cal. 2d 301, 223 P.2d 471 (1950), are cases which apparently follow this line of reasoning. *But see* Siverson v. Weber, 57 Cal. 2d 834, 372 P.2d 97, 22 Cal. Rptr. 337 (1962); Engelking v. Carlson, 13 Cal. 2d 216, 88 P.2d 695 (1939). For an extended analysis of the various applications of res ipsa loquitur to medical malpractice cases in California see Rubsamen, *supra.*

113. 66 Cal. 2d at 413, 426 P.2d at 534, 58 Cal. Rptr. at 134.

114. *Id.* at 414, 426 P.2d at 535, 58 Cal. Rptr. at 135 (Tobriner, J.) (concurring opinion).

indicated by the justice:

> In the light of the expansion of res ipsa loquitur undertaken by . . . the majority opinion in the present case, there can be little doubt that the net effect of the doctrine is to shift from plaintiffs to defendants the cost of a certain number of unexplainable accidents in which no meaningful basis exists for finding the defendants at fault.[115]

And again:

> [With such expansion, the court is] pursuing the laudable goal of shifting the losses occasioned by such accidents to the parties best able to protect against them through insurance . . . .[116]

As has been stated,[117] the doctrine of res ipsa assures the plaintiff of reaching the jury; although it is often emphasized that the defendant may rebut the inference of negligence with his own evidence and that the doctrine only warrants, but does not compel, the inference of negligence, the sympathy of juries for plaintiffs faced with disastrous losses is well-known. Thus the plaintiff has won much of his battle, especially in the more sympathetic situations, by merely getting his case before the jury. He then has a good chance of obtaining some level of monetary judgment, wholly without regard to whether he previously proves the negligent cause of the injury. In all, the expanded doctrine of res ipsa, allowing the plaintiff to reach the jury in an increasing number of situations, does indeed seem to be serving a "risk-shifting purpose" by holding physicians and hospitals strictly liable in certain cases.

In this regard, consideration will be given below to the very pertinent observation made by Justice Tobriner: "If public policy demands that defendants be held responsible for unexplained accidents without a reasoned finding of fault, such responsibility should be fixed openly and uniformly, not under the guise of negligence and at the discretion of a jury."[118]

Negligence—Affirmative Duty and Standard of Care

Not only is the plaintiff able to get the issue of negligence to the jury in more cases, the concept of "negligence" itself seems to be expanding. Before discussing the expansion of this concept, however, it should be noted that because the hospital premises are used largely by those who are (in some manner) infirm rather than by people of

115. *Id.* at 418, 426 P.2d at 538, 58 Cal. Rptr. 138.

116. *Id.* at 414, 426 P.2d at 535, 58 Cal. Rptr. 135.

117. See text accompanying notes 92-93 *supra.*

118. 66 Cal. 2d at 414, 416, 426 P.2d at 534, 537, 58 Cal. Rptr. at 134, 137 (Tobriner, J.) (concurring opinion).

average physical condition, a higher degree of reasonable care is imposed on the hospital (than on other places of public resort) in keeping its premises in reasonably safe condition. As to the expansion of the negligence concept, at a hearing on the subject of Malpractice Liability before the California Senate Subcommittee of General Research in October 1967, James Ludlam, legal counsel for the California Hospital Association, stated: "The fact that we do so much for our patients has meant that the patients and their protectors, the juries, have asked for more in the way of a standard of care."[119]

As we have already seen, the *Darling* case has broadened the direct duty of the hospital to furnish competent medical care.[120] In addition, we have seen the expanding duty of the hospital nurse to use her independent judgment and to challenge orders from the attending physician that seem dubious.[121] There are other indications that the duty of care towards the patient is becoming more stringent.

In a 1967 Washington case, *Adams v. State*,[122] a mental patient escaped from the hospital grounds and jumped in front of an automobile, seriously injuring herself. The reader may recall that in the California case of *Vistica v. Presbyterian Hospital and Medical Center*,[123] the hospital staff was aware that the mental patient had attempted suicide the day before in the very same manner in which she ultimately did commit suicide. On the other hand, in the *Adams* case, although the hospital staff was aware of the patient's tendency to inflict self-harm because of her previous actions, the mental patient had never before attempted to injure herself in the particular manner in which she did.[124] For a defendant to be held liable, it must be shown not only that the defendant's negligence caused the injury, but also that the resulting injury to the plaintiff was a reasonably foreseeable consequence of that negligence.[125] Thus, the defendant state in *Adams* argued that it was not liable—since the patient had never before, while at the hospital, attempted to "escape," the incident resulting in injury was unforeseeable.[126]

119. Transcript, *Hearings on Malpractice Liability Before the Subcomm. of General Research of the Senate of the State of California* at 31 (October 17, 1967) [hereinafter referred to as Transcript, *Malpractice Liability Hearings*].

120. See text accompanying notes 82-85 *supra.*

121. See text accompanying notes 52-58 *supra.*

122. 71 Wash. 2d 414, 429 P.2d 109 (1967).

123. 67 Cal. 2d 465, 432 P.2d 193, 62 Cal. Rptr. 577 (1967).

124. 71 Wash. 2d at 423, 429 P.2d at 114.

125. PROSSER § 50, at 288.

126. 71 Wash. 2d at 423, 429 P.2d at 114.

The court could have met this defense directly by saying that the particular manner in which the patient injured herself was foreseeable; in other words, that it was foreseeable that if the hospital grounds were left unguarded, a mental patient with suicidal or self-harming tendencies would try to escape and injure himself although never before attempting an escape. The court did not so restrict itself, but instead stated broadly that it was enough that the hospital employees foresaw that the patient "might commit an act which would result in injury to herself."[127] Such a statement, however, can be made about any mental patient with suicidal or self-harming tendencies. The court seems to be placing a duty on the hospital to guard these patients against all manner of suicide or self-harm, no matter how unusual, or risk the possibility of being held liable for failure to do so. As the defendant state argued,[128] the practical effect of the court's ruling was to impose strict liability on a hospital for whatever self-inflicted harm is done by such patients, although the court disagreed with this analysis.[129]

A Medical Injury Commission

We have seen that it is becoming easier for an injured individual to maintain, and win, an action against a hospital. The doctrines of charitable immunity and governmental immunity from suit are dying; the bases of hospital liability are expanding as the hospital's defenses to the respondeat superior doctrine are becoming more limited and the doctrine of corporate negligence is growing. The standard of care owed by the hospital and its employees to the patient is becoming more stringent, or in other words, the concept of negligence in this situation is expanding; furthermore, it is becoming easier for the plaintiff's case to reach a sympathetic jury. The lesson of more and more cases appears to be that everyone injured by medical negligence or by an unavoidable accident should be compensated.

The hospital field is not unique in experiencing this shift in liability from the plaintiff to the defendant; quite the contrary, the process we have observed in the hospital field is merely a small segment of a much larger phenomenon that is taking place in our society. As one attorney commented: "[W]hether we are willing to accept it or not, we are practicing in an age of expanding liability, and this is true whether we are talking about the legal profession, the medical profession, the government . . . charitable organizations . . . . [or] the

127. *Id.*
128. *Id.*
129. *Id.*

area of products liability."[130] This overall phenomenon, in turn, is indicative of a shifting societal concern—an increasing sympathy for the victims of accidents unavoidably cause by mass operations.

For the hospital, what is at stake is the cost of the liability insurance premium, a cost of no small importance. For example, over the past 10 years the cost to California hospitals for one million dollars of liability insurance coverage rose from $4.17 to $18.02 per bed per month, while from 1967 to 1968 this cost increased by over 40 percent.[131] The hospital's rising cost of insurance coverage, however, is not the only shortcoming of the present system. These figures do not include the cost of the premiums paid by doctors, nurses, and staff members for individual coverage, and with rates for medical malpractice insurance rising dramatically, these individuals are experiencing the same spiraling cost of insurance coverage.[132]

In his criticism of the present system, Professor Ehrenzweig has aptly listed the following shortcomings of the present system:

> 1. There remains the great burden on time, energy and peace of mind that is imposed on potential defendants by the continuous threat of strike suits by claim-prone patients and by the possibility of jury verdicts in excess of available or economically feasible insurance coverage. In the face of these threats both physicians and hospitals are likely to become increasingly wary of fruitful experimentation and hazardous treatments.
>
> 2. The present possibility of suits against several persons for the same incident compel each of such persons (including the hospital, the nurse and the physician) to carry his own liability insurance and thus to increase the over-all premium load to the disadvantage of the public as the ultimate consumer.
>
> 3. The wastefulness of multiple liabilities and premiums also appears in the redistribution by subrogation claims among liability insurers, of losses already distributed.
>
> 4. Since liability insurance is not compulsory, even the most valid claim may remain unsatisfied if the defendant is insolvent.
>
> 5. Since liability coverage usually excludes liability for criminal acts and acts performed in the state of intoxication or under the influence of drugs, and since the policy will usually contain conditions concerning settlement and cooperation, the patient may remain uncompensated even if the defendant carries insurance.
>
> 6. Finally, and perhaps most important, in many cases such recovery as is ultimately obtained by the patient, must be paid for with the strain and expense of protracted litigation.[133]

130. Mueller, *The Expanding Duty of the Hospital to the Patient*, 47 NEB. L. REV. 337, 338 (1967).

131. LINDER, GROUP LIABILITY INSURANCE PROGRAM, Exhibit 1 (California Hospital Ass'n, Mar. 14, 1969).

132. *See* Transcript, *Malpractice Liability Hearings, supra* note 119, at 60-64.

133. Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First*

Another disadvantage of the present system, and one of no less importance to the physician, is the potential destruction of his professional career by a well-publicized malpractice case and jury verdict. The injury giving rise to this publicized case can occur at any time, and with certain medical procedures the physician and his hospital face the risk of lawsuit either way they turn. For instance, as reported in the State Senate hearings on medical practice liability, James E. Ludlam, legal counsel for the California Hospital Association, stated:

> For example, it is legally risky to attempt a cardiac resuscitation. If there is brain damage the judgment could be in the hundreds of thousands, but if no attempt to resuscitate is made, then a wrongful death case may ensue. This is a judgment that must be made in literally seconds and involves many profound issues that can all be reviewed at extended leisure by a jury with 20-20 back vision. I think this is a very serious part of the problem to which we are referring because we are dealing in judgment areas. . . . Now, we are not attempting to justify substandard practice, but our impression is if we watch this field that it isn't the substandard doctors that are being sued and against whom these big judgments are coming in. In many instances these big judgments are in our very best hospitals and very best doctors. It is not because they are incompetent, but because they engage in a highly skilled and technical work where any mistake of judgment is classified as culpable negligence with liability.[134]

In hopes of offsetting these risks and the concomitant dramatic rise in malpractice insurance premiums, physicians in California have turned to the state legislature for relief; their efforts have not been too successful.[135] Similarly arbitration has been suggested as an alter-

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Step Toward the Displacement of Liability for "Medical Malpractice", 31 U. CHI. L. REV. 279, 283-84 (1964) [hereinafter referred to as Ehrenzweig].

134. Transcript, *Malpractice Liability Hearings*, *supra* note 119, at 36-37.

135. The following legislation was either sponsored or endorsed by the California Medical Association or by individual physicians:

1. AB 259 (1969), *enacted*, CAL. CODE CIV. PROC. § 405.8. This act requires plaintiff on motion by defendant in a malpractice action to file a cost bond of up to $500 for each professional defendant named up to a maximum bond of $1,000.
2. SB 519 (1969), *enacted*, CAL. BUS. & PROF. CODE § 2144.5. This relieves from liability any physician or surgeon who in good faith renders medical care to a person for a medical complication arising from prior care by another person so licensed.
3. SB 709 (1969), *enacted*, CAL. HEALTH & SAFETY CODE § 1426. The hospital and all members of the licensed hospital's cardio-pulmonary resuscitation "rescue team" are relieved from liability for acts or omissions of such rescue team.
4. SB 351 (1969). Defeated in the Senate. This bill would have altered the res ipsa loquitur doctrine.
5. SB 943 (1969). Defeated in the Senate. This would have limited damages recoverable in "Professional Malpractice" actions to $150,000.

native.[136] Again this merely carries the same tort system over into another forum, with less ability of the attorneys to control the proceedings and thus even less predictability of result. The answer, in our opinion, does not rest in patching up a system of assessing financial re-

6. S. Res. 54 (1969). Defeated in the Senate. It would have urged the State Bar of California to establish reasonable guidelines for the detection and elimination of non-meritorious medical malpractice lawsuits and for the discouragement of contingency fees in such cases.
7. AB 134 (1969). Defeated in the Assembly. This bill would have altered the burden of proof in a malpractice case to require plaintiff to prove (1) the degree of knowledge or skill possessed, or degree of care ordinarily exercised, by other persons in the same specialty or discipline practiced by the defendant in a similar community as the defendant, (2) the defendant lacked such skill and knowledge or failed to exercise such degree of care, (3) that as a proximate result of defendant's lack of such knowledge or skill or failure to exercise such degree of care, plaintiff sustained injuries. The bill added that there would be no presumption or inference of negligence on the part of defendant.
8. AB 135 (1969). Defeated in the Assembly. The bill would have altered statute of limitations for a malpractice case by having the one year statute begin on the date of the wrongful act and not from any other date, except upon proof of fraud or intentional concealment.
9. AB 1046 (1969). Defeated in the Assembly. It would have required a separate jury trial on the issue of liability in an action for professional negligence or malpractice upon motion of either party made within a specified time.
10. AB 1047 (1969). Defeated in the Assembly. This would have required that damages awarded for purposes of future medical treatment be deposited into court to be disbursed under supervision of the court.
11. AB 1261 (1969). Defeated in the Assembly. This bill would have had the superior court of each county establish and maintain a commission on personal injury awards to be available upon motion of either party in certain malpractice cases. It also provided that the commission's finding would be evidence to be considered by the jury.
12. AB 1756 (1969). Defeated in the Senate. According to this bill any party prior to commencement of a trial would have been authorized to serve an offer in writing to the other party to have judgment taken based upon the offer. If the party to whom the offer is made refused to accept it prior to trial and there was a judgment less favorable to him, that party would have been barred from recovering costs; the court would then have been authorized to order him to pay various costs of the other party, including fees of expert witnesses who were not regular employees of any party.

136. The California Hospital Association and the California Medical Association are sponsoring a pilot project in Southern California involving arbitration of medical malpractice disputes. Rules of arbitration have been developed in conjunction with the American Arbitration Association, and these rules have been incorporated into the standard "Conditions of Admission" form used by the participating hospitals. The patient has a 30 day option following discharge to decline arbitration as the sole means of resolving these malpractice disputes. This option feature was added in the hopes of avoiding the contract of adhesion difficulty. The hospital arbitration regulations are broad enough to cover all legal disputes between the hospital and the patient, including collection of the unpaid hospital bill. *Hospital Arbitration Regulations, California Hospital Association* (1969).

lief for malpractice accidents on the basis of finding fault—a will -o'-the-wisp at best—the answer lies in changing the system itself. The administrative cost, including delay and financial strain on the plaintiff, the disasterous economic and professional impact upon the physican and the hospital, are too high a price to pay to maintain the present system.

It is believed that the system could be made less costly, consume less time, and could return more benefits to those injured through the mass operation of medical practice by instituting a medical injury commission to adjudicate claims and administer compensation to the victim. Broadly outlined, under the commission system, strict liability would be substituted for negligence as the basis for recovery; the complainant would merely have to show that he was injured through a "hospital accident"; the amount of recovery would be administered by the commission according to schedules of compensation; attorney's fees would be fixed by the commission; the procedure before the commission would be of an informal nature; and the system would be financed by requiring hospitals to carry insurance either with a state fund established for the purpose or with a qualified private carrier.

Strict Liability

Strict liability may well be a desirable basis for recovery in cases where a person has been injured through a medical accident whether someone is at fault or not. The incisive statement of Justice Tobriner in the California Supreme Court case of *Clark v. Gibbons*[137] is pertinent here: "If public policy demands that defendants be held responsible for unexplained accidents without a reasoned finding of fault, such responsibility should be fixed openly and uniformly, not under the guise of negligence and at the discretion of a jury."[138]

Indeed, it might be noted that several arguments traditionally utilized against the charitable immunity doctrine can be utilized as arguments against discriminating between those patients injured accidentally and those injured by an employee's or hospital's negligence. For example, the Idaho Supreme Court in the 1966 case of *Bell v. Presbytery of Boise*,[139] in eliminating the charitable immunity doctrine, argued: "Personal injury is no less painful, disabling, costly or damage-producing simply because negligent harm is inflicted by a charitable insti-

137. 66 Cal. 2d 399, 426 P.2d 525, 58 Cal. Rptr. 125 (1967).
138. *Id.* at 416, 426 P.2d at 536, 58 Cal. Rptr. at 136.
139. 91 Idaho 374, 421 P.2d 745 (1966).

tution rather than a noncharitable one."[140] It can similarly be argued that "personal injury is no less painful, disabling, costly or damage-producing simply because" the harm is inflicted by an unavoidable accident rather than by someone's negligence.

The California case of *Meier v. Ross General Hospital*,[141] discussed above,[142] illustrates the issue of who should bear the cost of an innovating medical procedure. In that case the hospital, in line with its "open door policy," which is generally considered to be best for rehabilitating psychiatric patients with suicidal tendencies, did not remove the window cranks in the psychiatric wing, whereupon a mental patient with a prior history of attempted suicide jumped to his death from a second floor window. The court of appeal refused to hold that the defendant hospital was negligent as a matter of law in operating on the "open door policy," stating that "[t]he course of treatment followed necessarily involved a *calculated* risk that the patient might harm himself."[143] Although the decision was reversed on another ground by the supreme court,[144] both courts were correct in holding that the hospital was not necessarily negligent in adopting and implementing the scheme. When the costs involved in such an innovative procedure, including the risk of a certain incremental amount of suicide and self-harm successes, were consciously weighed against the benefits of such a procedure (in terms of rehabilitation), the hospital was justified in concluding that, despite the significant costs of the procedure, its benefits outweighed such costs.

The pertinent question is not whether such a determination involved negligence, but rather the more fundamental question of whether negligence is a viable doctrine in this situation. Stated succinctly, the question becomes: Who should bear the costs of these known and unavoidable (and non-negligent) losses? On the one hand, under a strict negligence theory, the individual victims would have to bear the losses (since, by hypothesis, the adoption and implementation of the scheme were not negligent). On the other hand, under the doctrine of strict liability, the cost of these incremental losses would result in a higher insurance premium to the hospital. This increased cost, however, ultimately would be passed on by the hospital to the ones who are receiving the peculiar benefits of the new system—the patients.

140. *Id.* at 376, 421 P.2d at 747.
141. 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968).
142. See text accompanying notes 107-09 *supra*.
143. Meier v. Ross Gen. Hosp., 67 Cal. Rptr. 471, 477 (1968).
144. 69 Cal. 2d at 434-35, 445 P.2d at 529-30, 71 Cal. Rptr. at 913-14.

Here again it would be appropriate to examine a traditional argument against charitable immunity: that of the unfairness of forcing the injured party to contribute indirectly to the charity by refusing him the opportunity to recover damages. A similar argument might be made against the unfairness of forcing the injured patient to contribute to the innovating procedure (by refusing him recovery simply because the determination and implementation of the procedure were wholly non-negligent).

Although many people argue that the doctrine of negligence is necessary to maintain the standards of care of an organization like a hospital, the facts do not support this conclusion. Under strict liability, the hospital will still strive to prevent negligence in order to keep its insurance premium as low as possible. Under the new system, prevention of negligence will no longer produce a liability insurance rate of zero; but such elimination of negligence will keep the insurance rate at the minimum, unavoidable-accident level. That the insurance premium and, particularly, the potential of an increased insurance premium is an effective incentive to maintain the standards of care of an organization such as a hospital is illustrated by the experience of industry under Workmen's Compensation plans.[145] In studying the industrial accident rate for the United States and California, one writer has pointed out that over the long run there has been a "marked downward trend in the incidence of, and time loss produced by, industrial accidents."[146]

More important, the policing of the standard of care should be approached directly rather than through the random, unpredictible approach of the current tort system. As stated by one physician:

> In this age of complexities involved in medicine it is totally unfair to impose the responsibility for determining whether a doctor used good medical judgment or not solely on a group of 12 lay people. Only physicians can determine whether sound medical judgment is used in any given case, if that is what we are really trying to determine.[147]

MediCal and Medicare have encouraged greater use of internal hospital peer review mechanisms to avoid the unnecessary utilization of hospital services and medical procedures so as to hold down the cost of these two government-financed programs.[148] It is our opinion that

145. *See generally* Leonard, *Insurance Coverage*, in CALIFORNIA WORKMEN'S COMPENSATION PRACTICE 465, 467-77 (Cal. Cont. Educ. Bar ed. 1963); CAL. INS. CODE §§ 11730 *et seq.*

146. Riesenfeld, *Efficacy and Costs of Workmen's Compensation*, 49 CALIF. L. REV. 631, 650 (1961).

147. Transcript, *Hearings on Malpractice Liability Before the Subcomm. of General Research of the Senate of the State of California* at 35 (Dec. 15, 1967).

148. *See generally* CAL. WELF. & INST'NS CODE §§ 14114, 14125.

similar peer review mechanisms within hospitals, the medical societies, the Board of Medical Examiners, and the State hospital-licensing agencies can be implemented along similar lines to provide much better policing of the standards of health care. Certainly the establishment and maintenance of an on-going system of controls at each of these levels with the requirement of periodic reports to the appropriate governmental agencies will be more accountable to the physicians, government, and to the general public than the current tort system. There is no question that the fear of malpractice litigation has encouraged physicians to implement new standards of care but at the same time it has also discouraged innovative approaches and procedures. It is submitted that a more direct method of supervising the quality of health care is preferable both for the patient and the physician.

Criminal Negligence

One of the assumptions of the proposed system is that a saving will be achieved by reducing litigation costs to defendants as well as plaintiffs. However, if as Professor Ehrenzweig has suggested, an exception from the commission system is provided for criminal negligence cases,[149] there is the possibility that claimants, in an attempt to receive higher awards than they might receive through the commission, may take their claims to court and attempt to prove criminal negligence, whether the defendant's conduct amounted to criminal negligence or not. Although the efficacy of the proposed system is not jeopardized by this possibility, it is jeopardized by the possibility that the courts and, in particular, the juries will award the plaintiff damages for conduct of the defendant which does not amount to criminal negligence. If this situation develops, the criminal negligence category, in time, could easily be used to encompass conduct that is simply ordinary negligence—the exception might become the rule.

This possibility should not be regarded lightly. It has been documented by two distinguished writers that in the case of air accidents under the Warsaw convention, the concept of criminal negligence has become a euphemism for ordinary negligence and a vehicle for bypassing the statutory awards.[150] It is also believed by the writers that much the same thing has occurred in the cases under the California guest statute.[151]

149. Ehrenzweig, *supra* note 133, at 290.

150. A. EHRENZWEIG, "FULL AID" INSURANCE FOR THE TRAFFIC VICTIM 27 (1954); Sand, *Limitation of Liability and Passengers' Accident Compensation Under the Warsaw Convention*, 11 AM. J. COMP. L. 21 (1962).

151. CAL. VEH. CODE § 17158.

On the other hand, criminal negligence should not go unnoticed. The persons responsible for criminal negligence can be held responsible for their acts both by the criminal law and by the hospital review committees discussed above. For these reasons, the writers are of the opinion that claims for injuries founded upon criminal negligence ought to be treated the same way under the proposed system as are claims for ordinary negligence and unavoidable injuries.

Hospital Accident

If strict liability is substituted for negligence as the basis for recovery, the patient will merely have to show the extent of his injury and that his claimed injury was not the proximate result of his condition when he entered the care of the hospital or its employees. The patient would not be required to identify any specific injuring party or to prove causative "negligence." An essential feature of both the present system and the proposed system is that a patient is not compensated for economic loss caused by the disease or other harm which originally led him to seek medical care. Such losses are compensated by private or governmental medical insurance programs.

The losses which the proposed system is intended to compensate are those that naturally arise from what we today identify as negligence, as well as the unavoidable accidents which occur in the mass operation of today's medical practice. Yet, one of the difficulties inherent in a system where recovery for medical injuries is based on strict liability is to distinguish between two situations, each of which may result in economic loss to the patient, but only one of which should be compensated for under the proposed system. One situation arises when the patient's post treatment condition is the product of the risk involved in any medical treatment; the other arises when the patient's treatment produces an abnormal result not within the risk of the treatment.

An example of the first situation is the development of an infection in an open wound that has been subjected to treatment. Such a development would ordinarily be considered a natural consequence of the patient's original condition when he entered the hospital, and any resultant economic loss would be covered, if at all, by the patient's own health insurance. Examples of the second situation would include the leaving of a sponge or other foreign matter in the patient,[152] or an injury to a part of the patient which is not the subject of treatment, such as an injury to an arm when the patient has had an operation on his

152. *E.g.*, Ales v. Ryan, 8 Cal. 2d 82, 64 P.2d 409 (1936).

leg.[153] Utilizing this distinction, therefore, that a patient has suffered what to him is an unexpected result in the course of medical treatment would not necessarily be sufficient reason to make the hospital liable, even under a system of strict liability. If the distinction discussed above is not made, the hospitals become insurers against all undesirable results—a situation that it is believed would create too great a financial burden for hospitals to carry. Probably no single term can adequately describe this distinction; but for the sake of convenience, some term must be adopted; and the term "hospital accident," which was first propounded by Professor Ehrenzweig,[154] is used here to describe this distinction.

While the word "accident" ordinarily connotes something sudden, unusual or unexpected, such as an unlooked-for mishap or an untoward event that is not expected or designed,[155] it would not be so limited under the proposed system. As Professor Ehrenzweig has pointed out, to be useful the term "hospital accident" would have to include "[s]ome such formula as that now used in malpractice insurance policies, namely the reference to 'services rendered or which should have been rendered . . . .' "[156] Perhaps the definition of "accident" as it has evolved under Workmen's Compensation plans would be helpful in identifying compensable injuries in the scheme of the medical injury commission. As one writer has pointed out, in the field of Workmen's Compensation "an unexpected cause or an unexpected result is sufficient to establish the injury as caused by 'accident'."[157] Here again, the phrase "unexpected result" would have to refer to a result unexpected according to medical knowledge at the time of the treatment. The phrase "unexpected result" should not be held to include infections or complications which occasionally occur from the type of treatment administered even though the infection or complication might occur in a very small percentage of cases.

Schedules of Compensation

An essential feature of the proposed system is a schedule of benefits by which much of the uncertainty of the current system would be eliminated. No attempt, however, will be made here to prescribe in

153. *E.g.*, Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944).

154. Ehrenzweig, *supra* note 133, at 284.

155. Morris v. New York Life Ins. Co., 49 F.2d 62, 63 (4th Cir. 1931); Hagger v. Wortz Biscuit Co., 210 Ark. 318, 196 S.W.2d 1 (1946); Fenton v. Thorley, [1903] A.C. 443.

156. Ehrenzweig, *supra* note 133, at 289.

157. Horovitz, *Workmen's Compensation: Half Century of Judicial Developments*, 1962 INS. L.J. 301, 310.

detail what such a schedule of benefits might provide. A general discussion of that nature may be found in another article.[158] Rather, the writers are primarily concerned here with the policy reasons for establishing a schedule of benefits and with the advantages, in general, that can be derived from such a plan.

Because the claimant would be required to seek compensation through the medical injury commission whether his injury was the result of an unavoidable accident, ordinary negligence, or criminal negligence, the provision for a schedule of benefits should eliminate a repetition of the astronomical judgments that the medical profession has witnessed in recent years. The writers, however, are in no way suggesting that the schedule of benefits should not compensate the injured victim. Indeed, great care should be taken to draft a schedule of benefits that does provide adequately for the losses suffered by the injured victims. All damages now recoverable in malpractice cases, including some recovery for pain and suffering, might well be included in such a schedule of benefits. But the awarding of compensation according to the schedule of benefits should prove to be a more consistent and objective method of compensating the claimant in medical injury cases than a jury verdict has been. The use of a schedule of benefits as the basis for determining the amount of an award to be made to the injured claimant should also aid insurance companies in establishing premiums for "hospital accident" insurance, that is, what we now call medical malpractice insurance, which accurately reflect the true risk involved—something that is not possible under the present system.

Attorney's Fees

Another essential feature of the proposed system is that attorney's fees will be set by the commission for each case that comes before it. It is proposed that attorney's fees be fixed much as they are fixed under the Workmen's Compensation plans.[159] Attorney's fees under the proposed system should reflect a closer correlation to the time spent on each case by the attorney than to a percentage of the judgment which he obtains for his client.

The elimination of any requirement of proving fault or identifying a particular person as having committed fault in a medical injury case, together with a schedule of compensation for the injured victim, should greatly reduce the guesswork involved in this kind of litigation. Since

158. Ehrenzweig, *supra* note 133, at 284-91.

159. *See generally* Swezey, *Lien Claims*, in CALIFORNIA WORKMEN'S COMPENSATION PRACTICE 567, 571-72 (Cal. Cont. Educ. Bar ed. 1963).

a fundamental assumption of the proposed system is that all medical injury victims, whether injured by negligence or not, should receive compensation for their injuries, it seems equitable that the attorney should be willing to forego a fee based purely upon a percentage of the award or recovery.

Again, it is believed that this proposal would contribute generally to a reduction of the costs involved in litigating medical injury cases and would also aid insurers in making accurate appraisals of the medical injury risk involved in treating patients in hospitals.

Informal Procedure

To reduce the costs of litigating medical injury claims and to expedite the hearing of such claims, it is important that the procedure before the proposed commission be of an informal nature. The person assigned to hear a medical injury case, a referee, for example, would have at his disposal a panel of doctors upon whom he could call for advice on any matter pertaining to the victim's claim. Medical and other testimony by the parties to the action could be received, in most cases, in the form of written reports or affidavits. The feature of the proposed system which allows the taking of testimony by written report or affidavit should be helpful in alleviating the cost of these proceedings. It is well known that today the costs of taking the testimony of an expert witness through his personal appearance before a court or examiner is much more expensive than the taking of the same testimony by written report or affidavit. The informal proceedings developed in administering Workmen's Compensation plans are an example of how the proposed medical injury commission might work.[160]

Insurance Coverage

Perhaps the greatest saving to be effectuated by the proposed plan would be in the area of insurance premiums. It is proposed that each hospital, whether public or private, be required to carry insurance either with a state fund established for the purpose or with a qualified private carrier. Since each person injured within the broad definition of a "hospital accident" would be required to bring his claim to the medical injury commission, and since his claim, if proven, would have to be paid for by the hospital in whose care the victim was at the time of the accident, the number of claims against individual doctors, nurses, interns, and other members of the medical profession should be greatly

160. *See generally* Connolly, *Setting for Trial*, in CALIFORNIA WORKMEN'S COMPENSATION PRACTICE 196-210 (Cal. Cont. Educ. Bar ed. 1963).

diminished. Under the proposed system neither the hospitals nor their insurers would be granted a subrogation of the injured victim's claim allowing them to commence a private civil action against a member of the health team for the amount of the award which the hospital or the insurer was required to pay to the injured victim. Thus, the proposed system would largely obviate the necessity for individual members of the medical profession to carry what is now called medical malpractice insurance. Instead, those individuals who would treat patients away from the hospital, and not as part of the hospital's general program, could participate in the hospital's insurance coverage on a group basis by paying an appropriate premium.

It often happens under the present system that there is substantial double coverage of medical malpractice insurance. A hospital pays substantial premiums for medical malpractice insurance for each doctor, nurse, or member of its staff, for the injuries they may cause while administering medical treatment in the hospital. In addition, the same individuals who, as mentioned above, are covered through the hospital, also pay substantial premiums for their own private coverage. These policies cover the administration of the same medical treatment; but each policy protects only the insured from the medical malpractice suits that may be brought against the insured as an individual. Under the proposed system, much of this double coverage could and would be eliminated.

Constitutionality of the Proposed System

The problem of the constitutionality of the proposed system should be no greater obstacle to its adoption than was the constitutional problem of adopting the Workmen's Compensation plans. The problem, of course, is that the state constitution provides that there shall be no limitation on the amount of recovery to which an injured person is entitled by reason of the tortious conduct of another. However, appropriate amendment to the state constitution could eliminate this problem, just as was done with the Workmen's Compensation plans.[161]

Conclusion

We have been rather broad and theoretical (as well as selective

161. The authority of the Legislature to confer judicial power upon the Workmen's Compensation Commission is derived wholly from CAL. CONST. art. 20, § 21. Carstens v. Pillsbury, 172 Cal. 572, 158 P. 218 (1916). *See generally* New York Cent. R.R. v. White, 243 U.S. 188 (1916); Bancroft, *Workmen's Compensation Coverage and Other Remedies*, in CALIFORNIA WORKMEN'S COMPENSATION PRACTICE 11-12 (Cal. Cont. Educ. Bar ed. 1963).

in our arguments) in our treatment of the questions of hospital liability, the doctrine of negligence as the basis of hospital liability, and an alternative system based upon strict liability. We adopted this approach because it was not our purpose to give a detailed analysis of the numerous and far reaching ramifications of an alternative theory of liability and its implementation. Nor did we intend to thrust ourselves into the position of advocates of a strict liability scheme. Rather, we wanted to suggest a novel (and, we believe, viable) line of argument in favor of strict liability: that such a system is, to a large extent, merely a logical extension of our policy reasons for ending charitable immunity and holding hospitals liable for negligence in the first place. In addition, we wanted to dispel what we feel is the most widely used, but erroneous argument against a system of strict liability—that it would eliminate the incentive to maintain a high standard of care.

More important, however, we wanted to emphasize the need to reappraise our present system. Indeed, if we are actually approaching a system of strict liability in effect, we should do so consciously rather than unconsciously and haltingly. We should fully and consciously assess this alternative basis of liability, and after such a complete consideration of the scheme, we can either accept, modify, or reject it completely. Indeed, once we take a direct look at and completely examine the doctrine and all of its ramifications, we might discover that public policy does *not* demand that defendants be held responsible without a finding of fault.

In any event, we can achieve reasoned, consistent results only after a complete and intelligent consideration of the question of the basis of liability. In the writers' opinion, we should stop depending upon the halting, inconsistent, haphazard, and fickle sympathy of differing juries to achieve surreptitiously a system that we think we want, although we are too unsure of our desires to overtly embrace this system or even to take a good, honest look at the whole problem.